ATTACHMENT B

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)
BASIC STATE GRANT (BSG), FY 2000 - 2004

The CAPTA – BSG program provides states with flexible funds to improve their child protective services (CPS) system in one or more of the following areas:

- Intake, assessment, screening and investigation of reports of abuse and neglect
- Protocols to enhance investigations
- Improve legal preparation and representation
- Case management
- Delivery of services provided to children and families
- Risk and safety assessment tools and protocols
- Automation systems that support the program and track reports of CAN
- Training for agency staff, service providers, mandated reporters
- Developing, strengthening and supporting CAN prevention, treatment and research programs in the public and private sectors.

States receiving CAPTA-BSG funds are required to transmit annually, on a calendar year basis, "to the maximum extent practicable", CAN reporting data, response times, services provided, case dispositions, deaths, caseloads, staffing, and GAL information including the number of out-of-court contacts with children. Reporting, through NCANDS, is considered "voluntary".

Accomplishments to date under CAPTA and update on the program areas selected for improvement:

1. Improving the CPS system in the area of <u>delivery of services</u> provided to children and families:

   - Diversion Services

     Expanded statewide the diversion of low and moderate risk cases to community providers to provide short-term (up to 6 weeks) outreach and follow-up, and link the family with appropriate community resources, public and private. Information on progress made is included under CFSP Final Report safety accomplishments.

2. Improving the CPS system in the area of support for <u>child abuse prevention and research</u>:

   - Child Death Reviews

     - In 1991, DHS requested assistance from the CWS State Advisory Council to conduct a retrospective review of CAN deaths and serious re-abuse cases, covering a 5-year period from 1987 to 1992. The purpose of the review was to insure that lessons learned would be identified and

changes made within the system in order to eliminate or reduce the chance of recurrence.

- In July 1997, the Department of Health (DOH) was authorized by HRS 321 to conduct systematic multidisciplinary reviews of all child deaths under age 18 to reduce preventable child deaths. The DOH State Child Death Review (CDR) system was officially established. The DOH CDR system is composed of over 80 professionals statewide. The State CDR Council meets quarterly while the 6 local CDR teams meet on an as needed basis to conduct case review and analysis.

- DOH established a surveillance system database incorporating available data reported from birth certificates, death certificates, CPS records, Medicaid/QUEST records, coroner/medical examiner records, and education, law enforcement, judiciary, and first responder information.

- Established and trained local CDR teams.

- Local CDR teams completed retrospective case reviews of child deaths occurring in 1996. The final report on their findings was completed in 2001.

- Completed case reviews of child deaths occurring 1997 – 2000; report will be issued in CY 2004.

- Preliminary findings related to deaths in **open child protective service (CPS) cases** reviewed (1997 – 2000) are summarized below.

  - 16 deaths in open CPS cases (1997 – 2000) were reviewed.
  - 10 of the 16 were female.
  - 7 of the 16 were Part-Hawaiian; 4 were Filipino.
  - 8 were Hawaii County cases; 8 were Oahu cases.
  - 8 were infants under 1 year old; 8 others were age 1 - 17.
  - Manner of death: 2 homicides; 5 accidental deaths; 5 natural deaths; and 4 undetermined.

- Preliminary findings related to deaths in **previously open child protective service (CPS) cases** reviewed (1997 – 2000) are summarized below.

  - 12 deaths in previously open CPS cases (1997 – 2000) were reviewed.
  - 7 of 12 deaths in previously open CPS cases (1997 – 2000) involved part-Hawaiian children.

- The following issues and preliminary recommendations were identified during local CDR team reviews as factors:

- Assure that CWS workers, foster parents, and service providers are aware of and alert to safe sleeping practice and exposure to second-hand smoke issues.
- Improve quality of assessments, including substance abuse assessment, and access to treatment for parents.
- Improve assessment and service planning to better address CWS-domestic violence issues.
- Improve documentation for death scene findings.
- Improve transitional support for foster parents caring for medically fragile children.
- Be aware of and better address gun control issues.
- Be aware of and address pedestrian and motor vehicle safety issues – e.g., risky driving on rural roads.

? The DOH Keiki Injury Prevention Coalition (KIPC), in its 2002 Action Plan, *"Protecting Our Children: Strategies for Injury Prevention,"* reported that during the 10-year period, 1991 – 2000, there were 70 deaths by homicide among children younger than 20 years; 31% (22) were less than 2 years old.

  Between 1996 -1999, 126 children were hospitalized for identified abuse, 71% (89) were less than 3 years old.

  The child abuse homicide rate undercounts fatal abuse as many highly suspicious cases cannot be confirmed by physical evidence and are coded as undetermined. Current hospital data coding significantly underestimates the number of children hospitalized for abuse.

  The Children's Justice Task Force and the DOH Child Death Review (CDR) have partnered and initiated training to improve scene investigation, forensic photography, autopsy and lab work.

Citizen Review Panels (CRP)

CRP recommendations for CWS improvement, FY 2000 – 2002, are highlighted below. FY 2003 reports were submitted for Kauai, Maui and West Hawaii, and are included in the CFSP, FY 2005 – 2009, report. No reports were submitted by East Hawaii for FY 2003, and Oahu for FY 2001, 2002 and 2003.

The following were among the CRP recommendations for improvement from FY 2000 – 2002:

? Change mandated reporting law provision requiring staff members of any public or private school, agency or institution to immediately notify the person in charge

or a designated delegate, who in turn shall immediately report to CWS; wants staff members to report directly to CWS (East Hawaii)

- Simplify and shorten CWS mandated reporter checklist (East Hawaii)
- Re-evaluate CWS management policies and practices; clearly define staff roles; make clear CWS performance and outcomes standards; improve performance and outcomes monitoring; establish a system of staff and management accountability (East Hawaii, Kauai, Maui)
- Address workload and staffing shortage; improve recruitment and retention of qualified staff; improve staff qualifications and job standards; improve staff training (East Hawaii, Kauai, Maui and Oahu)
- Improve notification and involvement of foster parents to afford them the opportunity to contribute to decision-making regarding children in their care (Kauai)
- Establish State centralized intake (Kauai)
- Recognize exposure to domestic violence as a harm in confirming CAN (Kauai)
- Make clear CWS policy and protocol for handling drug exposed infant cases (Kauai)
- Conduct regular local in-service meetings with service providers to improve communication, service integration (Kauai)
- Improve availability and access to residential drug treatment for parents (Kauai, Oahu)
- Improve foster/adoptive parent training; use trained and licensed/approved homes (Kauai)
- Improve understanding and use of risk assessment matrix (Kauai)
- Address adoption delays identified by key informants (Kauai)
- Improve POS monitoring and accountability, particularly monitoring of contracted diversion services; localize POS monitoring, or improve POS contracting, monitoring, and reporting for more accountability to local management (Maui)
- Improve availability and access to therapeutic foster homes (Maui)
- Improve community education (Oahu)